Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name
HARTFORD CASUALTY INSURANCE CO

Carrier's Austin Representative
Box Number 47

MFDR Tracking Number
M4-11-2503-01

MFDR Date Received
March 25, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to RULE §134.60 [sic] (p) 'Non-Emergency health care requiring preauthorization includes:.. (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program.' Therefore, an initial psychological interview (Initial Mental Health Evaluation) does not require pre-authorization. Please be advised that this patient was in a pre-authorized or Division exempted return-to-work rehabilitation program, therefore preauthorization for the repeat interview was not required."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Billing sent to incorrect billing fax #. Diagnosis code submitted invalid. Carrier has requested a valid code to process bill. Please see attached."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2010	90806	$200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

3. The services in dispute were not reduced/denied by the respondent. The respondent asserts that the requestor did not bill with a correct diagnosis and submitted the bill to the incorrect billing fax number. No EOBs were provided by either party.

Issues

1. Did the requestor submit the bill to the insurance carrier containing an invalid diagnosis code?
2. Did the insurance carrier audit the disputed charges?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.10 "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (M) diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code must be present."
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the ICD-9-CM Vol. 1 Code Detail – 886 Fourth Digit Code Required. Review of the CMS-1500 documents that the requestor billed with a three digit ICD-9 code that requires a fourth digit to help identify whether the injury was without mention of complications (886.0) or complicated (886.1).

   The insurance carrier submitted a copy of an email corresponding with Mr. Paul Rader that states in part "In order for us to process billing, we will need a correct diagnosis code. The code listed in box 21 (886) is not a valid code..."

   Review of the submitted documentation finds that the requestor billed with a valid code, however did not bill to the highest specificity as required when billing ICD-9 code 886.
3. Per 28 Texas Administrative Code §133.307, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   The documentation submitted also finds that the requestor's charges have not been audited by the insurance carrier, neither through initial audit nor a reconsideration audit, due to the return of the medical bill by the insurance carrier. Neither party provided the MDR section with copies of EOBs primarily due to no audit of the medical charges. As a result, the division finds that the requestor is not entitled to reimbursement for CPT code 90806 rendered on April 14, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.